

January 6, 2003

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TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M2-03-0353-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Orthopedic Surgery. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___ is a 44-year-old woman who injured herself while working for ___ on ___. Records indicate that she slipped and fell, landing on the floor. She was complaining of multiple symptoms to include upper back, lower back, right knee, right thumb, left elbow and bilateral hip pain. ___ was initially seen at an urgent care center with negative x-rays.

The patient had an exhaustive work-up to include two MRIs of the shoulder which demonstrated supraspinatus tendonitis. She had a cervical MRI which demonstrated a C6-7 disc bulge to the right side. She has had an EMG/NCS of the left upper extremity on July of 2001 which was negative.

In addition, the patient has seen several neurosurgeons who have recommended no surgical intervention. One specifically, ___, stated that the patient had many leery symptoms including dizziness, loss of balance, sleepiness, blurred vision and memory loss. None of these were consistent with her physical findings.

___ has seen ___, a neurologist. His evaluation was that there was no evidence of seizure disorder. She has had a CT scan of the brain that was negative. In addition, she has had an EEG and numerous other medical studies which have been negative.

In addition, there is some suspicion of somatoform disorder.

___ continues to complain of neck pain and upper extremity pain.

REQUESTED SERVICE

Cervical discectomy with fusion at C6-7 is requested for ___.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

___ EMG/NCS of July 2001 was within normal limits. In addition, she has had a cervical MRI which has shown a questionable minor disc bulge lateral to the right. The patient's symptoms are on the left. In addition, the records presented are filled with questionable "somatoform" disorder type presentation to include pain out of proportion to physical findings and multiple bizarre-type complaints. When a patient presents with vague, unexplained symptoms that cannot be substantiated by objective evidence, i.e., diagnostic studies and physical findings, surgery is unwarranted.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective *spinal surgery* decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other *prospective (preauthorization) medical necessity* disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).